
SECOND SUBSTITUTE HOUSE BILL 1432

State of Washington

69th Legislature

2025 Regular Session

By House Appropriations (originally sponsored by Representatives Simmons, Eslick, Rule, Davis, Macri, Stearns, Reed, Goodman, Salahuddin, Pollet, Timmons, and Santos)

READ FIRST TIME 02/28/25.

1 AN ACT Relating to improving access to appropriate mental health
2 and substance use disorder services by updating Washington's mental
3 health parity law and ensuring coverage of medically necessary care;
4 amending RCW 48.43.016, 48.43.410, 48.43.520, 48.43.530, 48.43.535,
5 48.43.600, 48.43.761, and 48.43.830; adding a new section to chapter
6 48.43 RCW; creating new sections; repealing RCW 48.20.580, 48.21.241,
7 48.41.220, 48.44.341, and 48.46.291; and providing an effective date.

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

9 NEW SECTION. **Sec. 1.** (1) The legislature finds that:

10 (a) Access to mental health and substance use disorder treatment
11 is critical to the health and well-being of individuals with these
12 conditions and that access to appropriate care is important to
13 reducing preventable emergency department visits, hospitalizations,
14 and physical health care costs associated with significant
15 comorbidities;

16 (b) Health insurance coverage is essential to ensuring that
17 individuals can access needed mental health and substance use
18 disorder treatment and that health carriers should make medical
19 necessity determinations based on the objective needs of the patient;
20 and

1 (c) The mental health and substance use disorder workforce faces
2 a number of administrative barriers and undue financial risks with
3 respect to participation in health carriers' provider networks that
4 should be alleviated.

5 (2) Therefore, it is the intent of the legislature to increase
6 access to mental health and substance use disorder treatment by
7 updating Washington's mental health parity requirements, requiring
8 that medical necessity determinations be consistent with generally
9 accepted standards of care and recommendations from nonprofit health
10 care provider associations, requiring consistent rules for both
11 mental health and substance use disorders, and eliminating harmful
12 barriers to care.

13 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43
14 RCW to read as follows:

15 (1) For the purposes of this section:

16 (a) "Clinical review criteria" means written guidelines,
17 standards, protocols, or decision rules used by a health carrier, or
18 health care benefit manager on behalf of a health carrier, during
19 utilization review to evaluate the medical necessity of a patient's
20 requested health care services.

21 (b) "Core treatment" means a standard treatment or course of
22 treatment, therapy, service, or intervention indicated by generally
23 accepted standards of mental health and substance use disorder care
24 for a condition or disorder.

25 (c) "Generally accepted standards of mental health and substance
26 use disorder care" means standards of care and clinical practice that
27 are generally recognized by health care providers practicing in
28 relevant clinical specialties such as psychiatry, psychology,
29 clinical sociology, social work, addiction medicine and counseling,
30 and behavioral health treatment. Valid, evidence-based sources
31 establishing generally accepted standards of care include peer-
32 reviewed scientific studies and medical literature, and
33 recommendations of nonprofit professional associations including, but
34 not limited to, patient placement criteria and clinical practice
35 guidelines, recommendations of federal government agencies, and drug
36 labeling approved by the United States food and drug administration.

37 (d) "Health plan" or "health benefit plan" means:

38 (i) A health plan as defined by RCW 48.43.005; or

1 (ii) A plan deemed by the commissioner to have a short-term
2 limited purpose or duration, or to be a student-only health plan that
3 is guaranteed renewable while the covered person is enrolled as a
4 regular, full-time undergraduate student at an accredited higher
5 education institution.

6 (e) "Medically necessary" means a service or product addressing
7 the specific needs of a patient, for the purpose of screening,
8 preventing, diagnosing, managing, or treating an illness, injury,
9 condition, or its symptoms, including minimizing the progression of
10 an illness, injury, condition, or its symptoms, in a manner that is:

11 (i) In accordance with generally accepted standards of mental
12 health and substance use disorder care;

13 (ii) Clinically appropriate in terms of type, frequency, extent,
14 site, and duration of a service or product; and

15 (iii) Not primarily for the economic benefit of the insurer or
16 purchaser or for the convenience of the patient, treating physician,
17 or other health care provider.

18 (f) "Mental health services" means:

19 (i) For health benefit plans issued or renewed before January 1,
20 2021, medically necessary outpatient and inpatient services provided
21 to treat mental disorders covered by the diagnostic categories listed
22 in the most current version of the diagnostic and statistical manual
23 of mental disorders, published by the American psychiatric
24 association, on June 11, 2020, or such subsequent date as may be
25 provided by the insurance commissioner by rule, consistent with the
26 purposes of chapter 6, Laws of 2005, with the exception of the
27 following categories, codes, and services: (A) Substance related
28 disorders; (B) life transition problems, currently referred to as "V"
29 codes, and diagnostic codes 302 through 302.9 as found in the
30 diagnostic and statistical manual of mental disorders, 4th edition,
31 published by the American psychiatric association; (C) skilled
32 nursing facility services, home health care, residential treatment,
33 and custodial care; and (D) court-ordered treatment, unless the
34 insurer's medical director or designee determines the treatment to be
35 medically necessary;

36 (ii) For a health benefit plan or a plan deemed by the
37 commissioner to have a short-term limited purpose or duration, or to
38 be a student-only health plan that is guaranteed renewable while the
39 covered person is enrolled as a regular, full-time undergraduate
40 student at an accredited higher education institution, issued or

1 renewed on or after January 1, 2021, medically necessary outpatient
2 services, residential care, partial hospitalization services, and
3 inpatient services provided to treat mental health and substance use
4 disorders covered by the diagnostic categories listed in the most
5 current version of the diagnostic and statistical manual of mental
6 disorders, published by the American psychiatric association, on June
7 11, 2020, or such subsequent date as may be provided by the insurance
8 commissioner by rule, consistent with the purposes of chapter 6, Laws
9 of 2005; and

10 (iii) For a health plan issued or renewed on or after January 1,
11 2027, medically necessary outpatient services, residential care,
12 partial hospitalization services, inpatient services, and
13 prescription drugs provided to treat mental health or substance use
14 disorders covered by:

15 (A) The diagnostic categories listed in the most current version
16 of the diagnostic and statistical manual of mental disorders,
17 published by the American psychiatric association, on June 11, 2020,
18 or such subsequent date as may be provided by the insurance
19 commissioner by rule, consistent with the purposes of chapter 6, Laws
20 of 2005; or

21 (B) The diagnostic categories listed in the mental, behavioral,
22 and neurodevelopmental chapters of the version available on January
23 13, 2025, of the international classification of diseases adopted by
24 the federal department of health and human services through 42 C.F.R.
25 Sec. 162.002 or any subsequent version as determined by the insurance
26 commissioner in rule consistent with this section and the goals
27 listed in section 1 of this act.

28 (g) "Nonprofit professional association" means a not-for-profit
29 health care provider professional association or specialty society
30 that is generally recognized by clinicians practicing in the relevant
31 clinical specialty and issues peer-reviewed guidelines, criteria, or
32 other clinical recommendations developed through a transparent
33 process.

34 (h) "Utilization review" means the prospective, concurrent, or
35 retrospective assessment of the medical necessity and appropriateness
36 of the allocation of health care resources and services of a provider
37 or facility, given or proposed to be given to an enrollee or group of
38 enrollees.

39 (2) Each health plan providing coverage for medical and surgical
40 services shall provide coverage for mental health services. Any cost

1 sharing for mental health services and any treatment limitations
2 related to mental health services must comply with the quantitative
3 and nonquantitative treatment limitation requirements in the mental
4 health parity and addiction equity act, 89 Fed. Reg. 77586 (September
5 23, 2024).

6 (3) Utilization review and clinical review criteria may not
7 deviate from generally accepted standards of mental health and
8 substance use disorder care.

9 (4) In conducting utilization reviews relating to service
10 intensity or level of care placement, continued stay, or transfer or
11 discharge, the health carrier shall apply relevant age-appropriate
12 patient placement criteria from nonprofit professional associations
13 and shall authorize placement at the service intensity and level of
14 care consistent with that criteria. The health carrier may not apply
15 different, additional, conflicting, or more restrictive criteria. If
16 the assessed level of placement is not available, the health carrier
17 shall authorize the next higher level of care. In the event of
18 disagreement with the provider, as part of the adverse benefit
19 determination, the health carrier shall provide full detail of its
20 assessment to the provider and the covered person.

21 (5) A health carrier may not limit benefits or coverage for
22 medically necessary mental health services on the basis that those
23 services should or could be covered by a public entitlement program
24 including, but not limited to, special education or an individualized
25 education program, medicaid, medicare, supplemental security income,
26 or social security disability insurance, and may not include or
27 enforce a contract term that excludes otherwise covered benefits on
28 the basis that those services should or could be covered by a public
29 entitlement program.

30 (6) This section applies to any health care benefit manager, as
31 defined in RCW 48.200.020 or contracted provider that performs
32 utilization review functions on a health carrier's behalf.

33 (7) A health carrier may not adopt, impose, or enforce terms in
34 its policies or provider agreements, in writing or in operation, in a
35 manner that undermines, alters, or conflicts with the requirements of
36 this section.

37 (8) If a health carrier provides any benefits for a mental health
38 condition or substance use disorder in any classification of
39 benefits, it shall provide meaningful benefits for that mental health
40 condition or substance use disorder in every classification in which

1 medical or surgical benefits are provided. For purposes of this
2 subsection, whether the benefits provided are considered "meaningful
3 benefits" is determined in comparison to the benefits provided for
4 medical conditions and surgical procedures in the classification and
5 requires, at a minimum, coverage of benefits for that condition or
6 disorder in each classification in which the health carrier provides
7 benefits for one or more medical conditions or surgical procedures. A
8 health carrier does not provide meaningful benefits under this
9 subsection unless it provides benefits for a core treatment for that
10 condition or disorder in each classification in which the health
11 carrier provides benefits for a core treatment for one or more
12 medical conditions or surgical procedures. If there is no core
13 treatment for a covered mental health condition or substance use
14 disorder with respect to a classification, the health carrier is not
15 required to provide benefits for a core treatment for such condition
16 or disorder in that classification, but shall provide benefits for
17 such condition or disorder in every classification in which medical
18 or surgical benefits are provided.

19 (9) The requirements related to the mental health parity and
20 addiction equity act, 89 Fed. Reg. 77586 (September 23, 2024), are
21 incorporated in this section in their entirety.

22 (10) If a health care provider or a current or prospective
23 covered person requests one or more nonquantitative treatment
24 limitation parity compliance analyses that the health carrier is
25 required to have completed by 29 U.S.C. Sec. 1185a or 42 U.S.C. Sec.
26 300gg-26, the health carrier shall provide the requested analyses
27 free of charge. The health carrier shall include in each of their
28 health plan policies and mental health and substance use disorder
29 provider contracts a notification of the right to request
30 nonquantitative treatment limitation analyses free of charge. The
31 notification must include information on how to request the analyses.
32 In addition to any other action authorized under RCW 48.02.080,
33 48.05.185, 48.44.166, and 48.46.135, failure by a health carrier to
34 provide the full requested analyses shall result in a penalty of \$100
35 per day, which shall be collected by the commissioner and remitted to
36 the requestor.

37 (11) If the commissioner determines that a health carrier has
38 violated this section, the commissioner may, after appropriate notice
39 and opportunity for hearing as required under chapters 48.04 and
40 34.05 RCW, by order, assess a civil monetary penalty not to exceed

1 \$5,000 for each violation, or, if a violation was willful, a civil
2 monetary penalty not to exceed \$10,000 for each violation. The civil
3 monetary penalties available to the commissioner pursuant to this
4 section are not exclusive and may be sought and employed in
5 combination with any other remedies available to the commissioner
6 under RCW 48.02.080. Beginning January 1, 2031, and every five years
7 thereafter, the penalty amounts specified in this section must be
8 adjusted based on the weighted cumulative average rate of change in
9 premium rates for the individual, small, and large group markets for
10 the previous five years.

11 (12) A violation of this section shall also be considered a
12 violation of RCW 48.43.0128.

13 (13) This section does not prohibit a requirement that mental
14 health services be medically necessary, if a comparable requirement
15 is applicable to medical and surgical services.

16 **Sec. 3.** RCW 48.43.016 and 2020 c 193 s 2 are each amended to
17 read as follows:

18 (1) A health carrier or its contracted entity that imposes
19 different prior authorization standards and criteria for a covered
20 service among tiers of contracting providers of the same licensed
21 profession in the same health plan shall inform an enrollee which
22 tier an individual provider or group of providers is in by posting
23 the information on its website in a manner accessible to both
24 enrollees and providers.

25 (2)(a) A health carrier or its contracted entity may not require
26 utilization management or review of any kind including, but not
27 limited to, prior, concurrent, or postservice authorization for an
28 initial evaluation and management visit and up to six treatment
29 visits with a contracting provider in a new episode of care for each
30 of the following: Chiropractic, physical therapy, occupational
31 therapy, acupuncture and Eastern medicine, massage therapy,
32 outpatient mental health care office visits, outpatient substance use
33 disorder care office visits, or speech and hearing therapies. Visits
34 for which utilization management or review is prohibited under this
35 section are subject to any quantitative treatment limits of the
36 health plan. Notwithstanding RCW 48.43.515(5) this section may not be
37 interpreted to limit the ability of a health plan to require a
38 referral or prescription for the therapies listed in this section.
39 Quantitative treatment limitations and nonquantitative treatment

1 limitations, including any referral and prescription requirements,
2 for mental health or substance use disorder care shall comply with
3 the requirements of the mental health parity and addiction equity
4 act, state law, and any implementing regulations.

5 (b) For visits for which utilization management or review is
6 prohibited under this section, a health carrier or its contracted
7 entity may not:

8 (i) Deny or limit coverage on the basis of medical necessity or
9 appropriateness; or

10 (ii) Retroactively deny care or refuse payment for the visits.

11 (3) A health carrier shall post on its website and provide upon
12 the request of a covered person or contracting provider any prior
13 authorization standards, criteria, or information the carrier uses
14 for medical necessity decisions.

15 (4) A health care provider with whom a health carrier consults
16 regarding a decision to deny, limit, or terminate a person's covered
17 health care services must hold a license, certification, or
18 registration, in good standing and must be in the same or related
19 health field as the health care provider being reviewed or of a
20 specialty whose practice entails the same or similar covered health
21 care service.

22 (5) A health carrier may not require a provider to provide a
23 discount from usual and customary rates for health care services not
24 covered under a health plan, policy, or other agreement, to which the
25 provider is a party.

26 (6) Nothing in this section prevents a health carrier from
27 denying coverage based on insurance fraud.

28 (7) For purposes of this section:

29 (a) "New episode of care" means treatment for a new condition or
30 diagnosis for which the enrollee has not been treated by a provider
31 of the same licensed profession within the previous ninety days and
32 is not currently undergoing any active treatment.

33 (b) "Contracting provider" does not include providers employed
34 within an integrated delivery system operated by a carrier licensed
35 under chapter 48.44 or 48.46 RCW.

36 **Sec. 4.** RCW 48.43.410 and 2019 c 171 s 2 are each amended to
37 read as follows:

38 For health plans delivered, issued for delivery, or renewed on or
39 after January 1, 2021, clinical review criteria used to establish a

1 prescription drug utilization management protocol must be evidence-
2 based and updated on a regular basis through review of new evidence,
3 research, and newly developed treatments. For prescription drugs
4 prescribed to treat mental health or substance use disorder
5 conditions, clinical review criteria must meet the requirements of
6 section 2 of this act.

7 **Sec. 5.** RCW 48.43.520 and 2000 c 5 s 8 are each amended to read
8 as follows:

9 (1) Carriers that offer a health plan shall maintain a documented
10 utilization review program description and written utilization review
11 and clinical review criteria based on reasonable medical evidence.
12 For mental health services, as defined in section 2 of this act,
13 clinical review criteria must meet the requirements of section 2 of
14 this act. The program must include a method for reviewing and
15 updating criteria. Carriers shall make clinical protocols, medical
16 management standards, clinical review criteria as defined in section
17 2 of this act, and other review criteria available upon request to
18 participating providers.

19 (2) The commissioner shall adopt, in rule, standards for this
20 section after considering relevant standards adopted by national
21 managed care accreditation organizations and state agencies that
22 purchase managed health care services.

23 (3) A carrier shall not be required to use medical evidence or
24 standards in its utilization review of religious nonmedical treatment
25 or religious nonmedical nursing care.

26 **Sec. 6.** RCW 48.43.530 and 2019 c 56 s 6 are each amended to read
27 as follows:

28 (1) Each carrier and health plan must have fully operational,
29 comprehensive grievance and appeal processes, and for plans that are
30 not grandfathered, fully operational, comprehensive, and effective
31 grievance and review of adverse benefit determination processes that
32 comply with the requirements of this section and any rules adopted by
33 the commissioner to implement this section. For the purposes of this
34 section, the commissioner must consider applicable grievance and
35 appeal or review of adverse benefit determination process standards
36 adopted by national managed care accreditation organizations and
37 state agencies that purchase managed health care services, and for
38 health plans that are not grandfathered health plans as approved by

1 the United States department of health and human services or the
2 United States department of labor. In the case of coverage offered in
3 connection with a group health plan, if either the carrier or the
4 health plan complies with the requirements of this section and RCW
5 48.43.535, then the obligation to comply is satisfied for both the
6 carrier and the plan with respect to the health insurance coverage.

7 (2) Each carrier and health plan must process as a grievance an
8 enrollee's expression of dissatisfaction about customer service or
9 the quality or availability of a health service. Each carrier must
10 implement procedures for registering and responding to oral and
11 written grievances in a timely and thorough manner.

12 (3) Each carrier and health plan must provide written notice to
13 an enrollee or the enrollee's designated representative, and the
14 enrollee's provider, of its decision to deny, modify, reduce, or
15 terminate payment, coverage, authorization, or provision of health
16 care services or benefits, including the admission to or continued
17 stay in a health care facility. Such notice must be sent directly to
18 a protected individual receiving care when accessing sensitive health
19 care services or when a protected individual has requested
20 confidential communication pursuant to RCW 48.43.505(5).

21 (4) An enrollee's written or oral request that a carrier
22 reconsider its decision to deny, modify, reduce, or terminate
23 payment, coverage, authorization, or provision of health care
24 services or benefits, including the admission to, or continued stay
25 in, a health care facility must be processed as follows:

26 (a) When the request is made under a grandfathered health plan,
27 the plan and the carrier must process it as an appeal;

28 (b) When the request is made under a health plan that is not
29 grandfathered, the plan and the carrier must process it as a review
30 of an adverse benefit determination; and

31 (c) Neither a carrier nor a health plan, whether grandfathered or
32 not, may require that an enrollee file a complaint or grievance prior
33 to seeking appeal of a decision or review of an adverse benefit
34 determination under this subsection.

35 (5) To process an appeal, each plan that is not grandfathered and
36 each carrier offering that plan must:

37 (a) Provide written notice to the enrollee when the appeal is
38 received;

39 (b) Assist the enrollee with the appeal process;

1 (c) Make its decision regarding the appeal within thirty days of
2 the date the appeal is received. An appeal must be expedited if the
3 enrollee's provider or the carrier's medical director reasonably
4 determines that following the appeal process response timelines could
5 seriously jeopardize the enrollee's life, health, or ability to
6 regain maximum function. The decision regarding an expedited appeal
7 must be made within seventy-two hours of the date the appeal is
8 received;

9 (d) Cooperate with a representative authorized in writing by the
10 enrollee;

11 (e) Consider information submitted by the enrollee;

12 (f) Investigate and resolve the appeal; and

13 (g) Provide written notice of its resolution of the appeal to the
14 enrollee and, with the permission of the enrollee, to the enrollee's
15 providers. The written notice must explain the carrier's and health
16 plan's decision and the supporting coverage or clinical reasons and
17 the enrollee's right to request independent review of the carrier's
18 decision under RCW 48.43.535.

19 (6) Written notice required by subsection (3) of this section
20 must explain:

21 (a) The carrier's and health plan's decision and the supporting
22 coverage or clinical reasons; and

23 (b) The carrier's and grandfathered plan's appeal or for plans
24 that are not grandfathered, adverse benefit determination review
25 process, including information, as appropriate, about how to exercise
26 the enrollee's rights to obtain a second opinion, and how to continue
27 receiving services as provided in this section.

28 (7) When an enrollee requests that the carrier or health plan
29 reconsider its decision to modify, reduce, or terminate an otherwise
30 covered health service that an enrollee is receiving through the
31 health plan and the carrier's or health plan's decision is based upon
32 a finding that the health service, or level of health service, is no
33 longer medically necessary or appropriate, the carrier and health
34 plan must continue to provide that health service until the appeal,
35 or for health plans that are not grandfathered, the review of an
36 adverse benefit determination, is resolved. If the resolution of the
37 appeal, review of an adverse benefit determination, or any review
38 sought by the enrollee under RCW 48.43.535 affirms the carrier's or
39 health plan's decision, the enrollee may be responsible for the cost
40 of this continued health service.

1 (8) Each carrier and health plan must provide a clear explanation
2 of the grievance and appeal, or for plans that are not grandfathered,
3 the process for review of an adverse benefit determination process
4 upon request, upon enrollment to new enrollees, and annually to
5 enrollees and subcontractors.

6 (9) Each carrier and health plan must ensure that each grievance,
7 appeal, and for plans that are not grandfathered, grievance and
8 review of adverse benefit determinations, process is accessible to
9 enrollees who are limited English speakers, who have literacy
10 problems, or who have physical or mental disabilities that impede
11 their ability to file a grievance, appeal or review of an adverse
12 benefit determination.

13 (10)(a) Each plan that is not grandfathered and the carrier that
14 offers it must: Track each appeal until final resolution; maintain,
15 and make accessible to the commissioner for a period of three years,
16 a log of all appeals; and identify and evaluate trends in appeals.

17 (b) Each grandfathered plan and the carrier that offers it must:
18 Track each review of an adverse benefit determination until final
19 resolution; maintain and make accessible to the commissioner, for a
20 period of six years, a log of all such determinations; and identify
21 and evaluate trends in requests for and resolution of review of
22 adverse benefit determinations.

23 (11) In complying with this section, plans that are not
24 grandfathered and the carriers offering them must treat a rescission
25 of coverage, whether or not the rescission has an adverse effect on
26 any particular benefit at that time, and any decision to deny
27 coverage in an initial eligibility determination as an adverse
28 benefit determination.

29 (12) A health carrier shall approve coverage of the mental health
30 services that are the subject of the grievance, appeal, or adverse
31 benefit determination if the health carrier does not respond to the
32 grievance, appeal, or adverse benefit determination within the time
33 frames required in this section.

34 **Sec. 7.** RCW 48.43.535 and 2022 c 263 s 4 are each amended to
35 read as follows:

36 (1) There is a need for a process for the fair consideration of
37 disputes relating to decisions by carriers that offer a health plan
38 to deny, modify, reduce, or terminate coverage of or payment for
39 health care services for an enrollee. For purposes of this section,

1 "carrier" also applies to a health plan if the health plan
2 administers the appeal process directly or through a third party.

3 (2) An enrollee may seek review by a certified independent review
4 organization of a carrier's decision to deny, modify, reduce, or
5 terminate coverage of or payment for a health care service or of any
6 adverse determination made by a carrier under RCW 48.49.020,
7 48.49.030, or sections 2799A-1 or 2799A-2 of the public health
8 service act (42 U.S.C. Secs. 300gg-111 or 300gg-112) and implementing
9 federal regulations in effect as of March 31, 2022, after exhausting
10 the carrier's grievance process and receiving a decision that is
11 unfavorable to the enrollee, or after the carrier has exceeded the
12 timelines for grievances provided in RCW 48.43.530, without good
13 cause and without reaching a decision.

14 (3) The commissioner must establish and use a rotational registry
15 system for the assignment of a certified independent review
16 organization to each dispute. The system should be flexible enough to
17 ensure that an independent review organization has the expertise
18 necessary to review the particular medical condition or service at
19 issue in the dispute, and that any approved independent review
20 organization does not have a conflict of interest that will influence
21 its independence.

22 (4) Carriers must provide to the appropriate certified
23 independent review organization, not later than the third business
24 day after the date the carrier receives a request for review, a copy
25 of:

26 (a) Any medical records of the enrollee that are relevant to the
27 review;

28 (b) Any documents used by the carrier in making the determination
29 to be reviewed by the certified independent review organization;

30 (c) Any documentation and written information submitted to the
31 carrier in support of the appeal; and

32 (d) A list of each physician or health care provider who has
33 provided care to the enrollee and who may have medical records
34 relevant to the appeal. Health information or other confidential or
35 proprietary information in the custody of a carrier may be provided
36 to an independent review organization, subject to rules adopted by
37 the commissioner.

38 (5) Enrollees must be provided with at least five business days
39 to submit to the independent review organization in writing
40 additional information that the independent review organization must

1 consider when conducting the external review. The independent review
2 organization must forward any additional information submitted by an
3 enrollee to the plan or carrier within one business day of receipt by
4 the independent review organization.

5 (6) The medical reviewers from a certified independent review
6 organization will make determinations regarding the medical necessity
7 or appropriateness of, and the application of health plan coverage
8 provisions to, health care services for an enrollee. The medical
9 reviewers' determinations must be based upon their expert medical
10 judgment, after consideration of relevant medical, scientific, and
11 cost-effectiveness evidence, and medical standards of practice in the
12 state of Washington. Except as provided in this subsection, the
13 certified independent review organization must ensure that
14 determinations are consistent with the scope of covered benefits as
15 outlined in the medical coverage agreement. Medical reviewers may
16 override the health plan's medical necessity or appropriateness
17 standards if the standards are determined upon review to be
18 unreasonable or inconsistent with sound, evidence-based medical
19 practice. For reviews of mental health services, as defined in
20 section 2 of this act, the medical reviewers must conduct reviews and
21 make determinations in a manner consistent with the requirements of
22 section 2 of this act.

23 (7) Once a request for an independent review determination has
24 been made, the independent review organization must proceed to a
25 final determination, unless requested otherwise by both the carrier
26 and the enrollee or the enrollee's representative.

27 (a) An enrollee or carrier may request an expedited external
28 review if the adverse benefit determination or internal adverse
29 benefit determination concerns an admission, availability of care,
30 continued stay, or health care service for which the claimant
31 received emergency services but has not been discharged from a
32 facility; or involves a medical condition for which the standard
33 external review time frame would seriously jeopardize the life or
34 health of the enrollee or jeopardize the enrollee's ability to regain
35 maximum function. The independent review organization must make its
36 decision to uphold or reverse the adverse benefit determination or
37 final internal adverse benefit determination and notify the enrollee
38 and the carrier or health plan of the determination as expeditiously
39 as possible but within not more than seventy-two hours after the
40 receipt of the request for expedited external review. If the notice

1 is not in writing, the independent review organization must provide
2 written confirmation of the decision within forty-eight hours after
3 the date of the notice of the decision.

4 (b) For claims involving experimental or investigational
5 treatments, the independent review organization must ensure that
6 adequate clinical and scientific experience and protocols are taken
7 into account as part of the external review process.

8 (8) Carriers must timely implement the certified independent
9 review organization's determination, and must pay the certified
10 independent review organization's charges.

11 (9) When an enrollee requests independent review of a dispute
12 under this section, and the dispute involves a carrier's decision to
13 modify, reduce, or terminate an otherwise covered health service that
14 an enrollee is receiving at the time the request for review is
15 submitted and the carrier's decision is based upon a finding that the
16 health service, or level of health service, is no longer medically
17 necessary or appropriate, the carrier must continue to provide the
18 health service if requested by the enrollee until a determination is
19 made under this section. If the determination affirms the carrier's
20 decision, the enrollee may be responsible for the cost of the
21 continued health service.

22 (10) Each certified independent review organization must maintain
23 written records and make them available upon request to the
24 commissioner.

25 (11) A certified independent review organization may notify the
26 office of the insurance commissioner if, based upon its review of
27 disputes under this section, it finds a pattern of substandard or
28 egregious conduct by a carrier.

29 (12)(a) The commissioner shall adopt rules to implement this
30 section after considering relevant standards adopted by national
31 managed care accreditation organizations and the national association
32 of insurance commissioners.

33 (b) This section is not intended to supplant any existing
34 authority of the office of the insurance commissioner under this
35 title to oversee and enforce carrier compliance with applicable
36 statutes and rules.

37 **Sec. 8.** RCW 48.43.600 and 2005 c 278 s 1 are each amended to
38 read as follows:

1 (1) Except in the case of fraud, or as provided in subsections
2 (2) and (3) of this section, a carrier may not: (a) Request a refund
3 from a health care provider of a payment previously made to satisfy a
4 claim unless it does so in writing to the provider within twenty-four
5 months after the date that the payment was made or, in the case of
6 mental health services as defined in section 2 of this act, within
7 six months after the date the payment was made; or (b) request that a
8 contested refund be paid any sooner than six months after receipt of
9 the request. Any such request must specify why the carrier believes
10 the provider owes the refund. If a provider fails to contest the
11 request in writing to the carrier within thirty days of its receipt,
12 the request is deemed accepted and the refund must be paid.

13 (2) A carrier may not, if doing so for reasons related to
14 coordination of benefits with another carrier or entity responsible
15 for payment of a claim: (a) Request a refund from a health care
16 provider of a payment previously made to satisfy a claim unless it
17 does so in writing to the provider within thirty months after the
18 date that the payment was made or, in the case of mental health
19 services as defined in section 2 of this act, within nine months
20 after the date the payment was made; or (b) request that a contested
21 refund be paid any sooner than six months after receipt of the
22 request. Any such request must specify why the carrier believes the
23 provider owes the refund, and include the name and mailing address of
24 the entity that has primary responsibility for payment of the claim.
25 If a provider fails to contest the request in writing to the carrier
26 within thirty days of its receipt, the request is deemed accepted and
27 the refund must be paid.

28 (3) A carrier may at any time request a refund from a health care
29 provider of a payment previously made to satisfy a claim if: (a) A
30 third party, including a government entity, is found responsible for
31 satisfaction of the claim as a consequence of liability imposed by
32 law, such as tort liability; and (b) the carrier is unable to recover
33 directly from the third party because the third party has either
34 already paid or will pay the provider for the health services covered
35 by the claim.

36 (4) If a contract between a carrier and a health care provider
37 conflicts with this section, this section shall prevail. However,
38 nothing in this section prohibits a health care provider from
39 choosing at any time to refund to a carrier any payment previously
40 made to satisfy a claim.

1 (5) For purposes of this section, "refund" means the return,
2 either directly or through an offset to a future claim, of some or
3 all of a payment already received by a health care provider.

4 (6) This section neither permits nor precludes a carrier from
5 recovering from a subscriber, enrollee, or beneficiary any amounts
6 paid to a health care provider for benefits to which the subscriber,
7 enrollee, or beneficiary was not entitled under the terms and
8 conditions of the health plan, insurance policy, or other benefit
9 agreement.

10 (7) This section does not apply to claims for health care
11 services provided through dental only health carriers, health care
12 services provided under Title XVIII (medicare) of the social security
13 act, or medicare supplemental plans regulated under chapter 48.66
14 RCW.

15 **Sec. 9.** RCW 48.43.761 and 2024 c 366 s 7 are each amended to
16 read as follows:

17 (1) Except as provided in subsection (2) of this section, a
18 health plan issued or renewed on or after January 1, (~~2021~~) 2027,
19 may not require an enrollee to obtain prior authorization for
20 withdrawal management services or inpatient or residential substance
21 use disorder or mental health treatment services in a behavioral
22 health agency licensed or certified under RCW 71.24.037.

23 (2)(a) A health plan issued or renewed on or after January 1,
24 (~~2021~~) 2027, must:

25 (i) Provide coverage for no less than two business days,
26 excluding weekends and holidays, in a behavioral health agency that
27 provides inpatient or residential mental health or substance use
28 disorder treatment prior to conducting a utilization review; and

29 (ii) Provide coverage for no less than three days in a behavioral
30 health agency that provides withdrawal management services prior to
31 conducting a utilization review.

32 (b)(i) The health plan may not require an enrollee to obtain
33 prior authorization for the services specified in (a) of this
34 subsection as a condition for payment of services prior to the times
35 specified in (a) of this subsection.

36 (ii) Once the times specified in (a) of this subsection have
37 passed, the health plan may initiate utilization management review
38 procedures if the behavioral health agency continues to provide
39 services or is in the process of arranging for a seamless transfer to

1 an appropriate facility or lower level of care under subsection (6)
2 of this section. For a health plan issued or renewed on or after
3 January 1, (~~2025~~) 2027, if a health plan authorizes inpatient or
4 residential mental health or substance use disorder treatment
5 services pursuant to (a)(i) of this subsection following the initial
6 medical necessity review process under (c)(iii) of this subsection,
7 the length of the initial authorization may not be less than 14 days
8 from the date that the patient was admitted to the behavioral health
9 agency. Any subsequent reauthorization that the health plan approves
10 after the first 14 days must continue for no less than seven days
11 prior to requiring further reauthorization. Nothing prohibits a
12 health plan from requesting information to assist with a seamless
13 transfer under this subsection.

14 (c)(i) The behavioral health agency under (a) of this subsection
15 must notify an enrollee's health plan as soon as practicable after
16 admitting the enrollee, but not later than (~~twenty-four~~) 24 hours
17 after admitting the enrollee. The time of notification does not
18 reduce the requirements established in (a) of this subsection.

19 (ii) The behavioral health agency under (a) of this subsection
20 must provide the health plan with its initial assessment and initial
21 treatment plan for the enrollee within two business days of
22 admission, excluding weekends and holidays, or within three days in
23 the case of a behavioral health agency that provides withdrawal
24 management services.

25 (iii) After the time period in (a) of this subsection and receipt
26 of the material provided under (c)(ii) of this subsection, the plan
27 may initiate a medical necessity review process. Medical necessity
28 (~~review~~) reviews for a primary diagnosis of substance use disorder
29 must be based on the standard set of criteria established under RCW
30 41.05.528. Medical necessity reviews for a primary diagnosis of a
31 mental health disorder other than a substance use disorder must
32 comply with the requirements of section 2 of this act. In a review
33 for inpatient or residential substance use disorder treatment
34 services, a health plan may not make a determination that a patient
35 does not meet medical necessity criteria based primarily on the
36 patient's length of abstinence. If the patient's abstinence from
37 substance use was due to incarceration, hospitalization, or inpatient
38 treatment, a health plan may not consider the patient's length of
39 abstinence in determining medical necessity. If the health plan
40 determines within one business day from the start of the medical

1 necessity review period and receipt of the material provided under
2 (c)(ii) of this subsection that the admission to the facility was not
3 medically necessary and advises the agency of the decision in
4 writing, the health plan is not required to pay the facility for
5 services delivered after the start of the medical necessity review
6 period, subject to the conclusion of a filed appeal of the adverse
7 benefit determination. If the health plan's medical necessity review
8 is completed more than one business day after the start of the
9 medical necessity review period and receipt of the material provided
10 under (c)(ii) of this subsection, the health plan must pay for the
11 services delivered from the time of admission until the time at which
12 the medical necessity review is completed and the agency is advised
13 of the decision in writing.

14 (3)(a) The behavioral health agency shall document to the health
15 plan the patient's need for continuing care and justification for
16 level of care placement following the current treatment period, based
17 on the standard set of criteria established under RCW 41.05.528, with
18 documentation recorded in the patient's medical record.

19 (b) For a health plan issued or renewed on or after January 1,
20 2025, for inpatient or residential mental health or substance use
21 disorder treatment services, the health plan may not consider the
22 patient's length of stay at the behavioral health agency when making
23 decisions regarding the authorization to continue care at the
24 behavioral health agency.

25 (4) Nothing in this section prevents a health carrier from
26 denying coverage based on insurance fraud.

27 (5) If the behavioral health agency under subsection (2)(a) of
28 this section is not in the enrollee's network:

29 (a) The health plan is not responsible for reimbursing the
30 behavioral health agency at a greater rate than would be paid had the
31 agency been in the enrollee's network; and

32 (b) The behavioral health agency may not balance bill, as defined
33 in RCW 48.43.005.

34 (6) When the treatment plan approved by the health plan involves
35 transfer of the enrollee to a different facility or to a lower level
36 of care, the care coordination unit of the health plan shall work
37 with the current agency to make arrangements for a seamless transfer
38 as soon as possible to an appropriate and available facility or level
39 of care. The health plan shall pay the agency for the cost of care at
40 the current facility until the seamless transfer to the different

1 facility or lower level of care is complete. A seamless transfer to a
2 lower level of care may include same day or next day appointments for
3 outpatient care, and does not include payment for nontreatment
4 services, such as housing services. If placement with an agency in
5 the health plan's network is not available, the health plan shall pay
6 the current agency until a seamless transfer arrangement is made.

7 (7) The requirements of this section do not apply to treatment
8 provided in out-of-state facilities.

9 (8) For the purposes of this section "withdrawal management
10 services" means twenty-four hour medically managed or medically
11 monitored detoxification and assessment and treatment referral for
12 adults or adolescents withdrawing from alcohol or drugs, which may
13 include induction on medications for addiction recovery.

14 **Sec. 10.** RCW 48.43.830 and 2023 c 382 s 1 are each amended to
15 read as follows:

16 (1) Each carrier offering a health plan issued or renewed on or
17 after January 1, 2024, shall comply with the following standards
18 related to prior authorization for health care services and
19 prescription drugs:

20 (a) The carrier shall meet the following time frames for prior
21 authorization determinations and notifications to a participating
22 provider or facility that submits the prior authorization request
23 through an electronic prior authorization process, as designated by
24 each carrier:

25 (i) For electronic standard prior authorization requests, the
26 carrier shall make a decision and notify the provider or facility of
27 the results of the decision within three calendar days, excluding
28 holidays, of submission of an electronic prior authorization request
29 by the provider or facility that contains the necessary information
30 to make a determination. If insufficient information has been
31 provided to the carrier to make a decision, the carrier shall request
32 any additional information from the provider or facility within one
33 calendar day of submission of the electronic prior authorization
34 request.

35 (ii) For electronic expedited prior authorization requests, the
36 carrier shall make a decision and notify the provider or facility of
37 the results of the decision within one calendar day of submission of
38 an electronic prior authorization request by the provider or facility
39 that contains the necessary information to make a determination. If

1 insufficient information has been provided to the carrier to make a
2 decision, the carrier shall request any additional information from
3 the provider or facility within one calendar day of submission of the
4 electronic prior authorization request.

5 (b) The carrier shall meet the following time frames for prior
6 authorization determinations and notifications to a participating
7 provider or facility that submits the prior authorization request
8 through a process other than an electronic prior authorization
9 process:

10 (i) For nonelectronic standard prior authorization requests, the
11 carrier shall make a decision and notify the provider or facility of
12 the results of the decision within five calendar days of submission
13 of a nonelectronic prior authorization request by the provider or
14 facility that contains the necessary information to make a
15 determination. If insufficient information has been provided to the
16 carrier to make a decision, the carrier shall request any additional
17 information from the provider or facility within five calendar days
18 of submission of the nonelectronic prior authorization request.

19 (ii) For nonelectronic expedited prior authorization requests,
20 the carrier shall make a decision and notify the provider or facility
21 of the results of the decision within two calendar days of submission
22 of a nonelectronic prior authorization request by the provider or
23 facility that contains the necessary information to make a
24 determination. If insufficient information has been provided to the
25 carrier to make a decision, the carrier shall request any additional
26 information from the provider or facility within one calendar day of
27 submission of the nonelectronic prior authorization request.

28 (c) In any instance in which a carrier has determined that a
29 provider or facility has not provided sufficient information for
30 making a determination under (a) and (b) of this subsection, a
31 carrier may establish a specific reasonable time frame for submission
32 of the additional information. This time frame must be communicated
33 to the provider and enrollee with a carrier's request for additional
34 information.

35 (d) The carrier's prior authorization requirements must be
36 described in detail and written in easily understandable language.
37 The carrier shall make its most current prior authorization
38 requirements and restrictions, including the written clinical review
39 criteria, available to providers and facilities in an electronic
40 format upon request. The prior authorization requirements must be

1 based on peer-reviewed clinical review criteria. The clinical review
2 criteria must be evidence-based criteria and must accommodate new and
3 emerging information related to the appropriateness of clinical
4 criteria with respect to black and indigenous people, other people of
5 color, gender, and underserved populations. The clinical review
6 criteria must be evaluated and updated, if necessary, at least
7 annually. Clinical review criteria used for purposes of reviewing and
8 decided upon prior authorization requests related to mental health
9 services, as defined in section 2 of this act, must meet the
10 requirements of section 2 of this act.

11 (2) (a) Each carrier shall build and maintain a prior
12 authorization application programming interface that automates the
13 process for in-network providers to determine whether a prior
14 authorization is required for health care services, identify prior
15 authorization information and documentation requirements, and
16 facilitate the exchange of prior authorization requests and
17 determinations from its electronic health records or practice
18 management system. The application programming interface must support
19 the exchange of prior authorization requests and determinations for
20 health care services beginning January 1, 2025, and must:

21 (i) Use health level 7 fast health care interoperability
22 resources in accordance with standards and provisions defined in 45
23 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

24 (ii) Automate the process to determine whether a prior
25 authorization is required for durable medical equipment or a health
26 care service;

27 (iii) Allow providers to query the carrier's prior authorization
28 documentation requirements;

29 (iv) Support an automated approach using nonproprietary open
30 workflows to compile and exchange the necessary data elements to
31 populate the prior authorization requirements that are compliant with
32 the federal health insurance portability and accountability act of
33 1996 or have an exception from the federal centers for medicare and
34 medicaid services; and

35 (v) Indicate that a prior authorization denial or authorization
36 of a service less intensive than that included in the original
37 request is an adverse benefit determination and is subject to the
38 carrier's grievance and appeal process under RCW 48.43.535.

39 (b) Each carrier shall establish and maintain an interoperable
40 electronic process or application programming interface that

1 automates the process for in-network providers to determine whether a
2 prior authorization is required for a covered prescription drug. The
3 application programming interface must support the exchange of prior
4 authorization requests and determinations for prescription drugs,
5 including information on covered alternative prescription drugs,
6 beginning January 1, 2027, and must:

7 (i) Allow providers to identify prior authorization information
8 and documentation requirements;

9 (ii) Facilitate the exchange of prior authorization requests and
10 determinations from its electronic health records or practice
11 management system, and may include the necessary data elements to
12 populate the prior authorization requirements that are compliant with
13 the federal health insurance portability and accountability act of
14 1996 or have an exception from the federal centers for medicare and
15 medicaid services; and

16 (iii) Indicate that a prior authorization denial or authorization
17 of a drug other than the one included in the original prior
18 authorization request is an adverse benefit determination and is
19 subject to the carrier's grievance and appeal process under RCW
20 48.43.535.

21 (c) If federal rules related to standards for using an
22 application programming interface to communicate prior authorization
23 status to providers are not finalized by the federal centers for
24 medicare and medicaid services by September 13, 2023, the
25 requirements of (a) of this subsection may not be enforced until
26 January 1, 2026.

27 (d)(i) If a carrier determines that it will not be able to
28 satisfy the requirements of (a) of this subsection by January 1,
29 2025, the carrier shall submit a narrative justification to the
30 commissioner on or before September 1, 2024, describing:

31 (A) The reasons that the carrier cannot reasonably satisfy the
32 requirements;

33 (B) The impact of noncompliance upon providers and enrollees;

34 (C) The current or proposed means of providing health information
35 to the providers; and

36 (D) A timeline and implementation plan to achieve compliance with
37 the requirements.

38 (ii) The commissioner may grant a one-year delay in enforcement
39 of the requirements of (a) of this subsection (2) if the commissioner

1 determines that the carrier has made a good faith effort to comply
2 with the requirements.

3 (iii) This subsection (2)(d) shall not apply if the delay in
4 enforcement in (c) of this subsection takes effect because the
5 federal centers for medicare and medicaid services did not finalize
6 the applicable regulations by September 13, 2023.

7 (e) By September 13, 2023, and at least every six months
8 thereafter until September 13, 2026, the commissioner shall provide
9 an update to the health care policy committees of the legislature on
10 the development of rules and implementation guidance from the federal
11 centers for medicare and medicaid services regarding the standards
12 for development of application programming interfaces and
13 interoperable electronic processes related to prior authorization
14 functions. The updates should include recommendations, as
15 appropriate, on whether the status of the federal rule development
16 aligns with the provisions of chapter 382, Laws of 2023. The
17 commissioner also shall report on any actions by the federal centers
18 for medicare and medicaid services to exercise enforcement discretion
19 related to the implementation and maintenance of an application
20 programming interface for prior authorization functions. The
21 commissioner shall consult with the health care authority, carriers,
22 providers, and consumers on the development of these updates and any
23 recommendations.

24 (3) A health carrier shall approve coverage of the mental health
25 services that are the subject of the prior authorization request if
26 the health carrier does not respond to the prior authorization
27 request within the time frames required in this section.

28 (4) Nothing in this section applies to prior authorization
29 determinations made pursuant to RCW 48.43.761.

30 ((4)) (5) For the purposes of this section:

31 (a) "Expedited prior authorization request" means a request by a
32 provider or facility for approval of a health care service or
33 prescription drug where:

34 (i) The passage of time:

35 (A) Could seriously jeopardize the life or health of the
36 enrollee;

37 (B) Could seriously jeopardize the enrollee's ability to regain
38 maximum function; or

39 (C) In the opinion of a provider or facility with knowledge of
40 the enrollee's medical condition, would subject the enrollee to

1 severe pain that cannot be adequately managed without the health care
2 service or prescription drug that is the subject of the request; or

3 (ii) The enrollee is undergoing a current course of treatment
4 using a nonformulary drug.

5 (b) "Standard prior authorization request" means a request by a
6 provider or facility for approval of a health care service or
7 prescription drug where the request is made in advance of the
8 enrollee obtaining a health care service or prescription drug that is
9 not required to be expedited.

10 NEW SECTION. **Sec. 11.** The insurance commissioner may adopt
11 rules:

12 (1) Necessary to administer and implement this act;

13 (2) Specifying data testing requirements to determine plan design
14 and in-operation parity compliance for quantitative and
15 nonquantitative treatment limitations, including but not limited to
16 prior authorization, concurrent review, retrospective review,
17 credentialing standards, and reimbursement rates. Such data testing
18 requirements may utilize independent generally recognized benchmarks
19 to determine parity compliance; and

20 (3) To ensure consistent utilization review and application of
21 clinical review criteria to meet the requirements of this act,
22 including identification of clinical review criteria that are
23 consistent with generally accepted standards of mental health and
24 substance use disorder care.

25 NEW SECTION. **Sec. 12.** Sections 1 through 10 of this act take
26 effect January 1, 2027.

27 NEW SECTION. **Sec. 13.** The following acts or parts of acts, as
28 now existing or hereafter amended, are each repealed, effective
29 January 1, 2027:

30 (1) RCW 48.20.580 (Mental health services—Definition—Coverage
31 required, when) and 2020 c 228 s 2 & 2007 c 8 s 1;

32 (2) RCW 48.21.241 (Mental health services—Group health plans—
33 Definition—Coverage required, when) and 2020 c 228 s 3, 2007 c 8 s 2,
34 2006 c 74 s 1, & 2005 c 6 s 3;

35 (3) RCW 48.41.220 (Mental health services—Definition—Coverage
36 required, when) and 2020 c 228 s 4 & 2007 c 8 s 6;

1 (4) RCW 48.44.341 (Mental health services—Health plans—
2 Definition—Coverage required, when) and 2020 c 228 s 5, 2007 c 8 s 3,
3 2006 c 74 s 2, & 2005 c 6 s 4; and

4 (5) RCW 48.46.291 (Mental health services—Health plans—
5 Definition—Coverage required, when) and 2020 c 228 s 6, 2007 c 8 s 4,
6 2006 c 74 s 3, & 2005 c 6 s 5.

7 NEW SECTION. **Sec. 14.** If specific funding for the purposes of
8 this act, referencing this act by bill or chapter number, is not
9 provided by June 30, 2025, in the omnibus appropriations act, this
10 act is null and void.

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